Public Health Watch

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METROPOLITAN HEALTH DEPARTMENT OF NASHVILLE AND DAVIDSON COUNTY, TENNESSEE

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Davidson County Child Death Review Team Issues 1997 Findings

Peggy Pharris, Support Staff of Child Death Review Team

There were 110 child deaths among Davidson County Residents in 1997. Of these 110 child deaths, 32 were preventable, that is, within the capability of the child or parents to prevent. In another 15 cases, the Team felt that the death could possibly have been prevented. In these cases, there was not enough information on which to make a formal decision or prevention depended on changes in the behavior of a third party. These are the new findings released by the Davidson County Child Death Review Team in a newly published report.

Other findings are:

Of these 110 child deaths, 76 were males and 34 were females, 54 African American, 51 white, two Hispanic, and three of other races. Planning District 14, (Donelson Hermitage area) had the largest number of child deaths - 18, followed by District 5 (East Nashville Inglewood area) with 15 deaths, and District 12 (Tusculum Crieve Hall area) with 13 deaths.

Firearms were the leading cause of death of teens (12 - 17) during this four-year period (1994 - 1997).

When child deaths were looked at by manner[1] of death and by cause, seventy-two percent or 79 deaths could be related to a natural manner of death, including known diseases (43%), prematurity (46%), and Sudden Infant Death Syndrome (SIDS) (11%). Eighteen percent or 20 deaths could be related to accidental manner of death. One-half of the accidental deaths were caused by vehicular accidents. The other causes were fires (4 deaths), suffocation (4 deaths), and drowning (3 deaths). Homicides made up 8% of the total deaths. Firearms were involved in seven of the nine homicide cases. In three cases, the victim was involved in criminal activity. One case was gang related. There was one child who died due to suicide.

Between January 1, 1994 and December 31, 1997 the Team gathered data on a total of 454 child deaths. The leading causes of death differed with age as reflected in the chart on page two. Firearms were the leading cause of death of teens (12 - 17) during this four year period.

The Davidson County Director of Health chairs the Team. Members include police officers, paramedics, nurses, behavior health professionals, physicians, medical examiner, district attorney, and child protective service workers.

Mayor Philip Bredesen established the Davidson County Child Death Review Team through Executive Order on January 5, 1994. The Team is required to review the deaths of all Davidson County children under 18. On June 12, 1995, Governor Don Sundquist signed the Child Fatality Review and Prevention Act of 1995. This bill created a Tennessee Child Fatality Prevention Team as well as local teams in all judicial districts. Nashville's Team had already been in operation for 18 months when the bill was signed.

continued on page two

IN THIS ISSUE

Child Death Review Team ....continued from page one

The full report will be available to download from the Metropolitan Health Department Home Page: www.nashville.org/health/cdr97.html. If you want a xerox copy, you may call Peggy Pharris at 615-340-0416. Any questions about the report or the Team's activities should be addressed to Dr. Stephanie Bailey at 615-340-5622.

[1] The five manners of death are *natural, accident, suicide, homicide,* and *could not be determined,* according to the death certificate.

Leading Causes of Child Deaths In Davidson County, 1994-1997

Rank	Under 1 Year	1-4 Years	5-11 Years	12-17 Years
1	Illness (200)	Illness (21)	Illness (22)	***Firearm (43)***
2	SIDS (39)	***Fire/Burns (6)***	***Vehicular (7)***	Illness (32)
3	***Suffocation (8)***	***Drowning (6)***	***Drowning (3)***	***Vehicular (31)***
4	***Lack of Adequate Care (2)***	***Inflicted Injury (5)***	***Firearm (1)***	***Suffocation (3)***
5	***Fire/Burns (2)***	***Vehicular (3)***	***Suffocation (1)***	***Poison/Drug overdose (2)***
6	***Inflicted Injury (2)***	SIDS (1)	***Fire/Burns (1)***	***Lack of Adequate Care (2)***
7	***Vehicular (1)***	***Firearm (1)***	***Lack of Adequate Care (1)***	***Fire/Burns (1)***
8		***Lack of Adequate Care (1)***	***Inflicted Injury (1)***	***Inflicted Injury (1)***
9			***Other (1)***	***Other (1)***

Causes of death are ranked within each age group. Causes indicated in bold italics are those that are considered preventable or potentially preventable.

Investigation of an Outbreak of Clostridium Perfringens

Jerry Rowland, Director of Retail Food Protection

On November 13, 1997, the Retail Food Protection Division at the Metropolitan Health Department received a complaint regarding a possible food poisoning involving twenty people who had attended a dinner party on November 8, 1997, at a friend's home. Sixteen people had become sick several hours after the meal with diarrhea and stomach cramps. It was determined that a food service establishment operating on the west side of the city had catered several of the foods for the dinner party. An inspector was dispatched immediately to the facility to obtain information surrounding the incident.

Case histories were collected on each of the persons attending the event. During the case history interviews, an attempt was initiated to obtain patient specimens but was unsuccessful. Information obtained during the initial case history interviews indicated that lasagna might have been the food implicated in the outbreak. Subsequently, the Fisher's exact test with a P value of .0002 was obtained which suggested that consumption of the lasagna was related to the observed illnesses. During the environmental health investigation, our staff found that the lasagna was not prepared in the establishment under investigation but was actually prepared in an unlicensed contract kitchen in the north Nashville area.

On the afternoon of November 14, 1997, the facility where the lasagna was prepared was inspected and a Notice of Administrative Action was issued to the operator to cease operations immediately. The chef at the facility was interviewed and a more in depth food history was obtained regarding the preparation of the suspected food. The information gathered revealed several breakdowns in the time/temperature controls of the product. The most glaring problem identified during the food preparation history was that the meat sauce, an ingredient of the lasagna, was not cooled rapidly. It was cooled in a large twenty-gallon stove pot inside the walk-in cooler allowing ample time for the bacterial spores to germinate and to produce new vegetative cells. Large quantities of food must be broken down and cooled in pans that are four inches thick or less to insure rapid chilling to prevent adequate time for bacterial multiplication. Listed below are additional problems identified:

1. Cooking temperatures were not being verified.

2. Cooling, reheating, and storage temperature were not being verified.

3. Adequate instructions were not provided regarding proper time/temperature controls of potentially hazardous foods after the foods were delivered to the customer.

One person had taken some of the lasagna home and had it stored in a freezer. The product was delivered to the Tennessee State Laboratory for analysis.

During the environmental health investigation, our staff found that the lasagna was not prepared in the establishment under investigation but was actually prepared in an unlicensed contract kitchen in the north Nashville area.

Information gathered during the case history interviews revealed that the ill people had a median incubation period of nine hours with predominant symptoms of stomach cramps and diarrhea. The decision was made to have the food analyzed for Clostridium perfringens, Bacillus cereus, and Staphylococcus aureus. A total plate count was requested as well.

Results – Total plate count >57million, Clostridium perfringens 10,500/gram, Bacillus cereus and Staphylococcus aureus analysis yielded negative results.

The total plate count >57 million is an indication that the product was contaminated. The bacterial count of 10,500 grams for C. perfringens is borderline according to the Centers for Disease Control and Prevention (CDC) guidelines regarding the bacterial load necessary to cause illness. However, realizing that the food sample had been frozen following the dinner, there is a strong possibility that many of the vegetative cells may have been destroyed prior to the sample being taken to the laboratory.

continued on page four

Investigation of an Outbreak of Clostridium Perfringens....continued from page three

The epidemiological and environmental data gathered during the investigation indicates that a common source outbreak occurred. The outbreak was most likely due to the lasagna being contaminated with Clostridium perfringens.

Food protection guidelines were established and issued to the owner of the business and subsequent visits have verified compliance. These guidelines are as follows:

1. All foods utilized in your operation must come from an approved source.

2. All staff persons must attend the Health Department's Food Protection Class.

3. Provide adequate calibrated bayonet food thermometers for all key personnel in order to monitor temperatures properly.

4. Establish procedures in the operation to insure that all foods are cooked (165°F), cooled, reheated, held and stored at proper temperatures. Also, provide a procedure for verification of temperatures.

5. Hot foods that are to be cooled must be cooled rapidly. Do not attempt to cool sauces in large pots in the refrigerator. Break the sauces down and place in 4 inch stainless steel pans then place in the cooler immediately, or use an ice bath.

6. Foods that have been cooked then cooled must be reheated to 165°F throughout before being served.

For additional information on surveillance and control of foodborne illnesses, check out the Centers for Disease Control and Prevention (CDC) website for the periodical "Emerging Infectious Diseases" at:

http://www.cdc.gov/ncidod/EID/current.htm.

The current issue, July-September 1998, contains information about:

- *Cyclospora cayetanesis* which caused the 1996 outbreak traced to raspberries,
- DNA fingerprinting for E coli O157:H7,
- Vancomycin resistant enterococci (VRE) in Europe related to the use of the antibiotic avoparsin in food animals,
- FoodNet, a nationwide computer network from CDC, U.S. Department of Agriculture (USDA), and U.S. Food and Drug Administration (FDA), striving to more precisely determine the frequency and severity of foodborne diseases in the U.S.

EPA REVISES NATIONAL AMBIENT AIR QUALITY STANDARDS FOR PARTICULATE MATTER AND OZONE

Rob Raney, Director of Pollution Control Division

Under the Clean Air Act, the U.S. Environmental Protection Agency (EPA) is required every five years to review the National Ambient Air Quality Standards (NAAQS) for six air pollutants – ground-level ozone, carbon monoxide, particulate matter, sulfur dioxide, nitrogen dioxide, and lead to determine whether revisions to the standards are necessary to continue to protect public health. On July 18, 1997, EPA issued revised National Ambient Air Quality Standards for Particulate Matter and Ozone.

EPA revised the form of the daily standard for particulate matter of 10 microns in diameter or less referred to as PM_{10}. EPA also adopted a new daily standard of 65.0 micrograms per cubic meter (ug/m^3) and a new annual standard of 15.0 micrograms per cubic meter (ug/m^3) for particulate matter of 2.5 microns in diameter or less referred to as $PM_{2.5}$. Based on past particulate matter monitoring data collected by the Pollution Control Division (PCD), Nashville air should comply with the revised PM_{10} NAAQS. A $PM_{2.5}$ monitoring network must be deployed and three years of $PM_{2.5}$ ambient monitoring data must be collected, beginning in 1999, in order to determine whether or not Nashville air will comply with the new fine particulate NAAQS.

EPA estimates that the particulate matter standards along with other clean air programs will reduce premature deaths by about 15,000 a year and reduce respiratory problems in children by 250,000 cases per year.

Particulate matter is the general term for solid and liquid particles found in the atmosphere. Coarse particulate matter between 2.5 and 10 microns in diameter comes from sources such as windblown dust and grinding operations. Fine particulate matter, less than 2.5 microns in diameter, often comes from commercial, industrial, and residential fuel combustion and vehicle exhaust. Fine particles are also formed in the atmosphere when gases such as sulfur dioxide, nitrogen oxides, and volatile organic compounds emitted by combustion activities, are transformed by chemical reactions in the atmosphere.

Exposure to particulate matter can result in the aggravation of respiratory conditions such as asthma, increased hospital admissions and emergency room visits, increased respiratory symptoms and disease, decreased lung function, and in some cases premature death. EPA's scientific review concluded that fine particulate, which penetrates deeply into the lungs, are more likely than coarse particulate to contribute to increased hospital admissions and premature mortality. EPA estimates that the new particulate matter standards along with other clean air programs will reduce premature deaths by about 15,000 a year and reduce respiratory problems in children by 250,000 cases per year.

EPA also adopted a new 8-hour Ozone NAAQS of 0.08 parts per million (ppm) based on the 3-year average of the annual 4^{th} highest daily maximum 1-hour ozone concentrations. The new 8-hour standard will replace the existing 1-hour standard of 0.12 ppm in areas such as Nashville that are in attainment with the 1-hour standard.

Ozone is a colorless pungent gas that is produced in the atmosphere by the reaction of volatile organic compounds and acid gases, such as nitrogen oxides in the presence of sunlight. Ozone is a seasonal pollutant occurring normally from April through September when warm sunny weather occurs. Studies conducted in the northeastern U.S. and Canada show that ozone air pollution is associated with 10% to 20% of all of the summertime respiratory-related hospital admissions. EPA has determined that the new ozone standard will help protect people who spend up to 8 hours a day working or playing outdoors, a group that is particularly vulnerable to the effects of ozone.

EPA's study concluded that the existing 1-hour standard did not adequately protect the public from adverse health effects. Therefore, EPA is replacing the previous standard with an 8-hour standard set at 0.08 ppm. An area will demonstrate attainment with the standard when the 3-year average of the annual 4^{th} highest daily maximum 8-hour concentration is below 0.08 ppm. Attainment/non-attainment classifications will be based on the data collected during the ozone seasons of 1997 – 1999. In the year 2000, EPA will formally determine

continued on page six

EPA Revises Air Quality Standards....continued from page five

which areas of the country do not meet the new 8-hour ozone standard and "designate" the areas as "non-attainment." In the interim, all areas of the country must continue to implement the programs that lead to attaining the 1-hour standard. Based on the previous three years of ozone data collected by the PCD and the Tennessee Air Pollution Control Division, the Middle Tennessee area is not presently meeting the new 8-hour standard even though the Middle Tennessee area has been designated by EPA as being in attainment with the 1-hour standard.

For additional information, contact the Metropolitan Health Department of Nashville and Davidson County, Pollution Control Division at 340-5653.

NASHVILLE AIR QUALITY DATA AVAILABLE ON INTERNET

The Pollution Control Division (PCD) of the Metropolitan Health Department of Nashville and Davidson County (MHD) is pleased to announce the addition of air quality data to the MHD website. The web address is:

http://www.nashville.org/health/psipoll.html

The air quality website can also be reached by accessing the MHD homepage at:

http://www.nashville.org/health

and clicking on Air Quality. The site contains the Pollution Standard Index (PSI) for Nashville, Tennessee, as prepared by PCD personnel twice daily. The site also contains daily pollen counts during the pollen season.

Numerous air pollution related websites may be accessed from the MHD home page by clicking on "Programs" and then on "Air Pollution Control Links". Likewise, many of the various forms used by the PCD along with copies of the Air Pollution regulations can be accessed from the MHD home page by clicking on "Forms".

Letters to the Editor

We welcome letters to the Editor. Not all letters can be printed, but all will be carefully considered for inclusion. Letters that are printed may be edited for space consideration. Letters should be addressed to:

Editor, *Public Health Watch*
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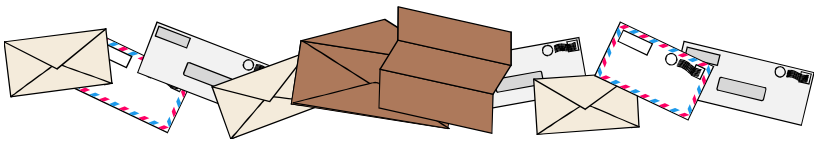
Room 210
Nashville, TN 37203



E-mail address: jesse_huang@mhd.nashville.org

INFLUENZA PREVENTION CAMPAIGN

Immunization Management Team

As fall nears, it is not too early to turn attention toward preparation for influenza prevention campaigns. In the U.S., influenza related illnesses accounted for 20,000 deaths during each of 11 different epidemics from 1972 - 1973 through 1994 - 1995. Vaccination levels in the U.S. among persons 65 years and older increased from 23% in 1985 to 58% in 1995, however, the influenza immunization level remains short of the Healthy People 2000 goal of 60%.[1] More alarming is the low immunization level among the African American population. The influenza immunization level among African Americans is about half of that of the white population.[2] The campaign against influenza is also an excellent time to review the immunization history and to update other immunizations accordingly.

Preparation for the 1998 – 1999 influenza season should include consideration of these guidelines:

- Obtain influenza vaccine prepared for 1998 – 1999 season. Discard any vaccine remaining from the previous year.
- Review and follow guidelines in "Morbidity and Mortality Weekly Report (MMWR) Prevention and Control of Influenza, May 1, 1998". This can be obtained from the CDC worldwide web server.
- Review and follow the package insert enclosed in the vaccine for contraindications, warnings, precautions, adverse reactions, dosage, and administration.
- Avoid starting vaccination programs too far in advance. Optimal time is October through mid-November.
- Reduce missed opportunities to vaccinate persons at high risk and especially encourage African American clients.
- Offer pneumococcal vaccine to those over 65 years and other at-risk groups previously unvaccinated.
- Review tetanus/diphtheria histories and update as indicated.
- Encourage medical providers to receive the flu vaccine.

[1] Centers for Disease Control and Prevention. "Prevention and Control of Influenza", Recommendations of the Advisory Committee on Immunization Practices; 1998, MMWR,47(RR-06).

[2] U.S. Department of Health and Human Services, Health Care Finance Administration, HCFA Press Office, news release "HHS Reports 58% of Elderly Received Flu Shots in 1995, 8% Higher Than in 1993", May 16, 1997.

BACK TO SCHOOL

SCHOOL HEALTH PROGRAM EXPANDS FOR 1998/1999

Karen Gore, Director of School Health Program

The Metropolitan Health Department's School Health Program began in the fall of 1996 to provide nursing services to medically eligible students and the general school population. The School Health Program was initiated by contractual agreement with the Metropolitan Department of Education as a result of legislation signed in April 1996 by Governor Don Sundquist. This legislation states that while students may be assisted with taking medication at school by school personnel, the nursing procedures must be done by nurses. Nursing procedures may involve G-tube feedings, catheterizations, injections, inhalation treatments, blood glucose monitoring, and tracheostomy care. Although the nurses do not do medication administration, monitoring of a safe medication delivery system is a priority.

The job description of the school registered nurses is not confined solely to performance of nursing procedures. They are also involved in activities with the general school population including instruction regarding health-related subjects, sharing in the interdisciplinary process, front-line defense with communicable disease, and serving as a medical resource for faculty and students.

Students requiring nursing services are referred to as IDEA (Individuals with Disabilities Education Act)/504 individuals and must be referred to school health through Special Education Services of the Department of Education.

Currently, twenty-four nurses serve 52 schools. Eventually, 125 schools will receive services. The presence of special needs students requiring daily services of the school nurse have, thus far, determined the placement of a nurse in a particular school. Other schools (not more than 2) within close proximity are then given access to this nurse for consultant and emergency services to their general school population and staff. Three Davidson County schools at present require the services of one or more nurses full-time due to the number of students with special health care needs.

Beginning in July 1998 ten additional registered nurses will be hired for the 1998 – 1999 school year. Schools that have been selected by the Department of Education as needing a nursing presence include the McGavock, Stratford, and Antioch "clusters". This includes the high schools and their feeder schools.

The goal of the School Health Program is to offer services to as many schools as possible with the thirty-four funded positions and to demonstrate the effectiveness and necessity of having school nurses in every school. For additional information about the School Health Program, call Annette Goodrum at 340-5614.

HEALTH REFERENCE MANUAL FOR SCHOOLS

Denise Stratz, RN

A team comprised of representatives from School Health, Immunization, Head Lice, and Communicable Disease Control programs at the Metropolitan Health Department of Nashville and Davidson County is nearing completion of a Health Reference Manual for schools. The purpose of the manual is to provide school secretaries, teachers, principals, and assistant principals with information on health issues that are dealt with daily in the schools. The manual will include: 1) necessary health forms; 2) immunization schedules and regulations; 3) fact sheets on childhood diseases which can be photocopied for parents; 4) contact numbers at the Health Department; 5) Health Department center sites; 5) simplified exclusion policies; and 6) information for dispensing medications in schools.

BACK TO SCHOOL: HEAD LICE ISSUES

Denise Stratz, RN

Head lice is a problem which has become increasingly difficult to address. The Metropolitan Health Department of Nashville and Davidson County implemented a proactive preventative approach to head lice at the beginning of the 1997 school year. This program focuses on school-wide checks at the beginning of school, after Christmas break, after spring break, and random monthly checks. Children identified with head lice at times other than a routine check are sent home with up-to-date head lice information and clear instructions that they must be nit-free to return to school. The entire classroom is then checked to prevent an outbreak, and a contact letter is sent home with those children who have been exposed so that parents can examine their children for lice for the next few days to prevent further spread.

Principals have begun referring chronic patients to the head lice program for intensive instruction. The ability to halt head lice in the chronic patient impacts a school tremendously. School personnel, school nurses, and the Head Lice Hotline have all seen a decrease in the incidence of head lice and head lice calls due to this effort.

Davidson County schools have a **no-nit** policy. This means a child must be totally nit-free to go back to school. Recent literature indicates that as many as 30% of nits may remain viable after treatment. Having a no-nit policy encourages home screening, helps eliminate treatment confusion (old or new nits), helps prevent reinfestation and transmissions, helps equalize the efficacy of commercial remedies, and eliminates the need for subsequent treatment. The Head Lice Hotline number is 340-7779 for Davidson County residents who need education concerning head lice and the problems associated with infestation.

NEW IMMUNIZATION REQUIREMENTS

Mary Fowler, Manager of Immunization Program

The Advisory Committee on Immunization Practices (ACIP) and American Academy of Pediatrics (AAP) have recommended changes to the school immunization schedule. ***Effective July 1, 1998, Measles Mumps Rubella (MMR) #2 is required for entry into grades kindergarten, four, eight, and twelve.*** This will be expanded to cover all grades in year 2001. A second dose of MMR will also be required for entry into colleges or universities.

Effective at the beginning of the 1999 school year, Hepatitis B will be required for children entering kindergarten.

Revised immunization standards for day care centers went into effect September 1, 1997. These standards specify that:

- All children must be age-appropriately immunized using the most current CDC/ACIP/AAP schedule.
- Hepatitis B vaccine is required for all children born after September 1, 1997.

IMMUNIZATIONS

PERINATAL HEPATITIS B PROGRAM

Denise Stratz, Coordinator of Perinatal Hepatitis B Program

Transmission of hepatitis B virus (HBV) from mother to infant during the perinatal period is one of the most prevalent modes of HBV infection. Infants born to mothers positive for hepatitis B surface antigen (HbsAg) have up to an 85% chance of acquiring perinatal HBV infection. Infants who become infected during the perinatal period have a 90% risk of chronic infection. Severe long-term sequelae can develop, ranging from fulminant hepatitis B in infancy to hepatocellular carcinoma or cirrhosis of the liver in adulthood. Twenty-five percent of people who develop hepatocellular carcinoma or cirrhosis of the liver in adulthood will die.

To address and prevent these serious complications of hepatitis B, the Metropolitan Health Department's Perinatal Hepatitis B Program offers services to pregnant women, their infants, and their household contacts. The services include: 1) counseling pregnant women and their household contacts regarding the disease; 2) identification, free testing, and vaccination of sex partners and household members who are susceptible; 3) completion of the baby's vaccine series free of charge, and 4) post-vaccination screening for infants after completion of the vaccine series.

In June 1997 a new Enhanced Perinatal Hepatitis B Pilot Program was implemented. This program offered hepatitis B education and outreach activities to health care providers in hospitals, clinics, medical facilities, and laboratories. As a result of the educational/outreach activities from June to December 1997 referrals to the Perinatal Hepatitis B Program increased by 82%. Denise Stratz, Perinatal Hepatitis B Program Coordinator for Davidson County, presented these results at the National Hepatitis Coordinators Conference in May 1998 in a presentation entitled "Implementing an Enhanced Perinatal Hepatitis B Pilot Program through Public-Private Collaboration". It was well received.

All perinatal patients who are HbsAg positive whether in a chronic or acute state need to be referred to this program. A referral can be made by calling Denise Stratz, RN, at 340-2174 or faxing the referral to 340-2176.

Prevention of Heat Related Illness and Death

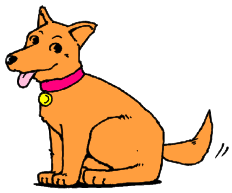
Risk Factors for Heat Related Deaths*:

- Alcohol consumption,
- Overweight,
- Use of some medications such as neuroleptics and tricyclic antidepressants,
- Physical activity such as exertion in unusually hot environments,
- Age: very young and elderly,
- History of previous heatstroke,
- Chronic conditions such as cardiovascular or respiratory diseases,
- Social circumstances such as living alone,
- Physical/mental impairments that interfere with ability to care for oneself/avoid hot environments.

Strategies to Prevent Heat Related Illness*:

- √ Acclimation to the climate and consultation with health professionals to establish exercise routines,
- √ Exercise during cooler parts of the day,
- √ Increased time in air-conditioned environments,
- √ Increased nonalcoholic fluid intake,
- √ Educate parents about the higher sensitivity to heat of children <5 years of age.

*Source: Morbidity and Mortality Weekly Report, 1998, 47 (No.23) 475.



ANIMAL SAFETY/RESPONSIBLE PET OWNERSHIP PROGRAM

Billy Hendrixson, Humane Education Specialist of Animal Control Division

Who would you tell if you saw a stray animal on the playground? "The teacher," one student said. "The principal," said another student.

"That's right," states Larry Cole, Director of the Animal Control Division of the Metropolitan Health Department, "tell an adult." Always remember: "If it is not your pet, leave it alone." Mr. Cole, along with Billy Hendrixson, a Humane Education Specialist, presented an animal safety program to over 12,000 students in Davidson County last year and would like to make the presentation to more students this year.

The Animal Control Division has several programs dealing with responsible pet ownership and animal safety. Programs are presented in elementary schools from pre-kindergarten through sixth grade. The Animal Control Division also has programs available for presentation to civic and community organizations.

Anyone interested in any of the Responsible Pet Ownership/Animal Safety Programs should contact the Animal Control Division at (615) 862-7931.

Cumberland Elementary School
February 6, 1998

Reported Cases of Selected Notifiable Diseases in Davidson County, TN for May/June, 1998

Disease	Total Reported May/June 1998	Year-to-Date Total	Total Reported May/June 1997
AIDS	20	56	26
Campylobacteriosis	3	5	3
Chickenpox	20	45	96
Chlamydia	357	1004	303
DRSP (Invasive drug-resistant Streptococcus pneumoniae)	3	25	0
E coli O157:H7	2	2	0
Giardiasis	3	5	1
Gonorrhea	346	906	332
Hepatitis A	14	26	8
Hepatitis B (acute)	0	50	47
Hepatitis B (perinatal)	5	11	Not available
Hepatitis C (acute)	0	3	2
HIV	29	119	66
Influenza	1	687	0
Salmonellosis	9	24	9
Shigellosis	2	3	12
Syphilis (Primary and Secondary)	29	102	67
Tuberculosis	13	35	24
VRE (Vancomycin-resistant enterococci)	18	47	4

To report a notifiable disease, please contact:

Sexually transmitted diseases: Dederick Yeargin at 340-5647

Perinatal hepatitis B: Denise Stratz at 340-2174

Vaccine-preventable diseases: Mary Fowler at 340-7787

Tuberculosis: Suprenia Bond at 340-5650

All other notifiable diseases: Mary Ellen Chesser at 340-5632